Safe and Just Culture

Heartland Consumers Power District
Winter Conference
Flandreau, SD | Nov. 15, 2018

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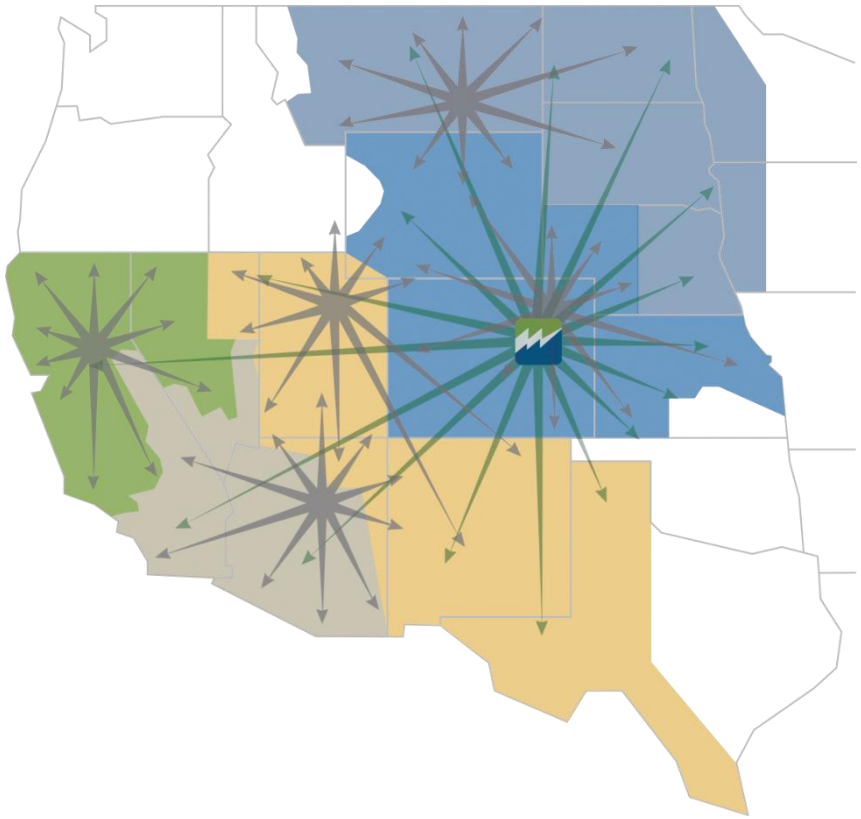
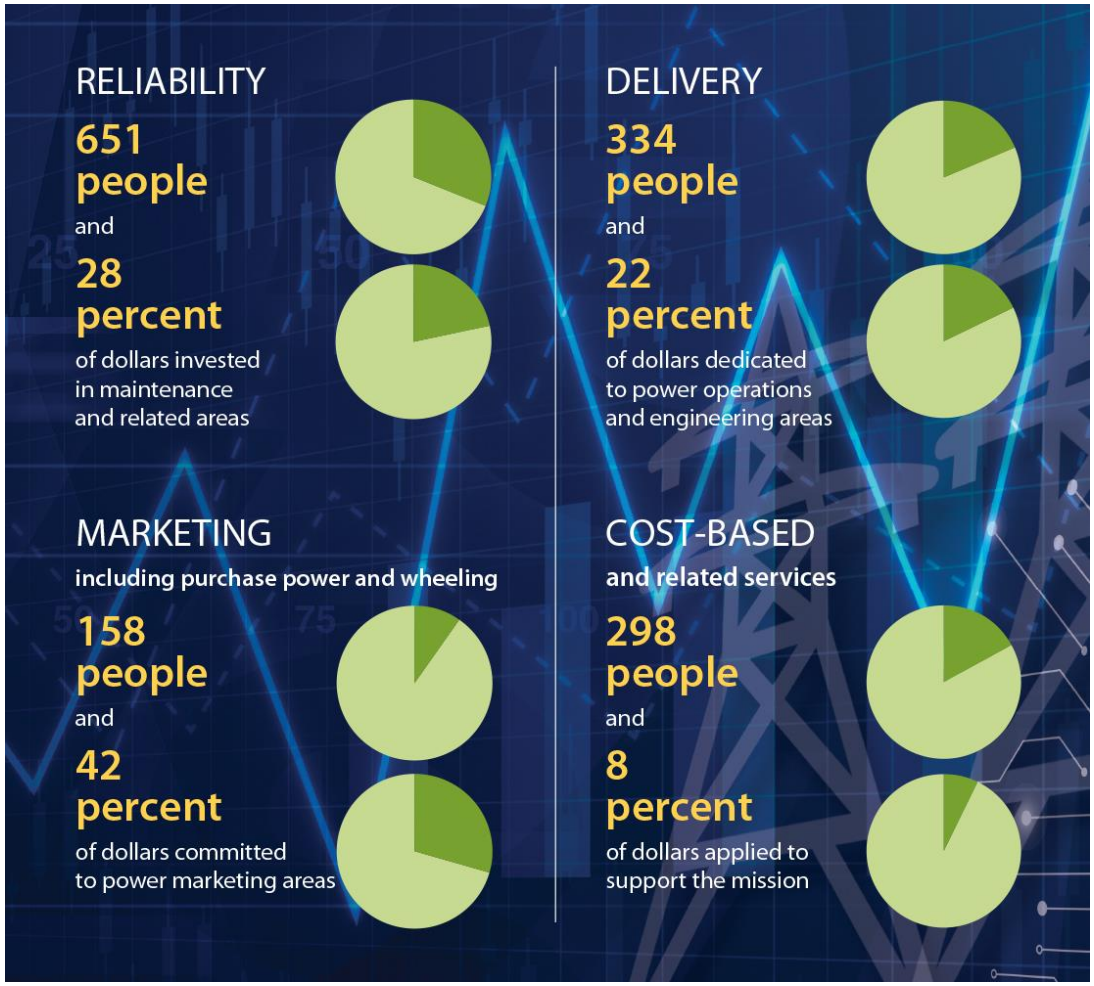
Administrator and CEO

Who we are

- Serve 40 million Americans
- 15-state footprint
- 1.4 million square miles
- 49 offices
- ~700 customers
- Top-10 largest transmission utility in country



Mission breakout



Core Values

Listen to understand, speak with purpose

Seek. Share. Partner.

Be curious, learn more, do better. Repeat.

Respect self, others and environment.

Do what is right. Do what is safe.

Serve like your lights depend on it.

Human Performance & Just Culture

- HP: The people side of process
  - Three-way checks
  - Near-miss reporting
  - Job hazard briefings /tailboards
- Just Culture: Handling HP in a fair & objective way
  - Human
  - At-Risk
  - Reckless

FY 2018 safety record

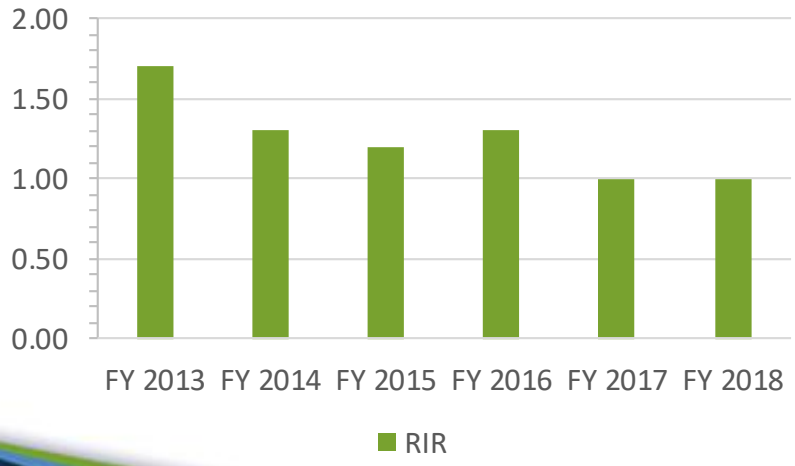
- Safety incident rate of 1.0
- Zero-incident safety culture
- Safety Incentive Program
- Increase in near-miss reports
- Confined space training
- 18 Learning Summaries
- 2 Incident Root-Cause reports

FY 2018 OSHA accomplishments

Recordable Incident Rate

Green Target: <= 1.5 (at year-end)

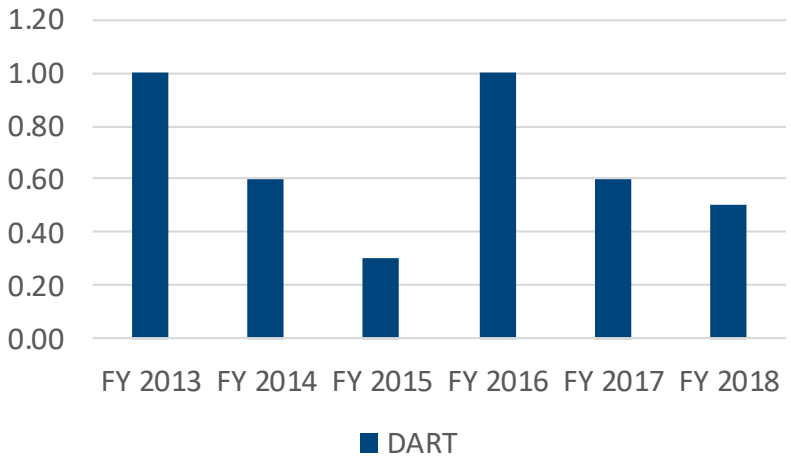
RIR = 1.0



Days Away, Restricted or Transferred

Green Target: <= 0.8 (at year-end)

DART = 0.5



FEVS results

Question	FY18 Positive	5-year trend (FY14 thru FY18)
Response Rates	65.0%	
Employee Engagement: Overall	70.7%	
Employee Engagement: Leaders Lead	56.6%	
Employee Engagement: Supervisors	78.6%	
Employee Engagement: Intrinsic Work Experience	76.8%	
Global Satisfaction	71.8%	
New IQ: Overall	63.6%	
New IQ: Fair	50.7%	
New IQ: Open	61.0%	
New IQ: Cooperative	59.3%	
New IQ: Supportive	80.6%	
New IQ: Empowering	66.6%	

Communicating about safety

Safety WORKS

April 2018

WESTERN AREA POWER ADMINISTRATION

Staying Out of "the Bite"

Almost half of injuries at WAPA during 2017 were "struck-by" incidents that involved employees being hit by equipment or other objects – also known as being in "the bite" or in "the line of fire."

Struck-by incidents represented some of WAPA's more serious injuries. An employee was knocked unconscious by a disconnect switch containing stored energy and another was struck by a wooden crossarm. WAPA has averaged five struck-by incidents per year since 2014.

We are not alone in facing this challenge. "Struck-by" is one of the highest causes of death nationwide in the construction industry, according to OSHA. The agency also reports that 75 percent of struck-by fatalities involve heavy equipment. Other hazards include objects under tension or loads, falling and flying objects, unsecure loads and unstable equipment or materials.

Injury prevention methods include use of proper rigging, effectively securing equipment, safely releasing tension and loads, staying out of the bite, avoiding distractions (e.g. cellphones, talking to others) and keeping eyes and mind on the task.

Other prevention strategies focus on situational awareness, hazard identification and communication. These include evaluating job-specific settings, identifying project hazards such as stored energy or heavy equipment and implementing site-specific control measures.

An employee was struck by a wooden crossarm last year

Communication of specific job-related hazards and challenges during preproject or tailgate meetings does not take long and can prevent injury. These meetings strengthen group awareness by keeping everyone involved, informed, alert and safe. A focused and informed team or crew will naturally watch out for one another.

Finally, personal responsibility is important. The saying, "If you see something, say something" is good advice for protecting yourself and coworkers from struck-by injuries and other safety incidents. If a near miss occurs, inform your regional safety office so that others can learn from and prevent similar events in the future by staying out of the bite. ■

Safe Driving Shorts

Distracted Driving: Think about driving the entire length of a football field at 55 MPH with your eyes closed. That's what it is like when you are distracted from the highway for five seconds. Distracted driving includes any activity that takes your mind or eyes off the road: eating, talking, phone calls, texting, emails, social media and more.

Solution: Don't drive distracted; drive and arrive safely.
Source: nhtsa.gov

Backing Up: Since 1999, More than 50 driving incidents at WAPA have involved backing up.

Solutions: Perform vehicle walk-arounds to identify obstacles, eliminate distractions, focus on the task, designate a spotter when backing up and discuss backing up during tailgate meetings.
Source: WAPA Motor Vehicle Incident Log

Rear-End Crashes: Rear-end collisions account for 29 percent of all accidents nationally.

Prevention: Practice the three-second rule and increase following distance when conditions require (e.g., slippery roads, low visibility and when following large or frequently stopping vehicles). Also, stay alert, be aware of surroundings, check mirrors regularly and stay out of blind spots.
Source: nhtsa.gov

Learning Summary — *Safety and Occupational Health*

WESTERN AREA POWER ADMINISTRATION

Crushed Finger Incident

Date Reported: August 24, 2018

What Happened? Event Description

A WAPA employee crushed and fractured his middle finger while unloading triple-flighted screw anchors from a four-walled trailer.

The employee's unloading method included lifting the front of the screw anchor up in the air at a 45-degree angle with his left hand, while simultaneously lifting the base with his right hand and thrusting the anchor forward. This action pushed the anchor up and over the top of the trailer wall, where it would fall onto the ground.

The employee successfully unloaded several of the screw anchors using this technique, however toward the end of the task, he misjudged a throw and the anchor fell short of clearing the trailer wall, crushing his left middle finger between the anchor and the top of the trailer.

Photographs

Photographs of the trailer and the triple-flighted screw anchors involved with this incident are presented on the following page.

Contributing Factors

A Learning Review Team identified the following contributing factors to this event.

- The event occurred at the end of the work day, which caused a rushing state to complete the job of unloading the anchors.
- Trust in the method used to unload the anchors, which had worked previously without incident.
- The practice of a commonly used "one person unloading method," instead of a two person method.

Lessons Learned

- Always take the time to assess the situation and make sure that you are not in any of the following four states:
  - Rushing
  - Frustration
  - Fatigue
  - Complacency

  Note: These are states that only you can identify and measure, while performing a task.
- When faced with the end of workday time crunch, remember that slow and steady gets the job done more efficiently (slow is fast) than a faster pace (fast is slow), which can lead to injury.
- Always take the time to assess each job and perform duties in the safest manner possible.
- If needed, get help.

Question for Discussion

- How can I "self-trigger on the state," or identify if I am becoming fatigued?
- Does rushing to perform duties always lead to good results?
- How can having assistance add exponentially to the success of work completion without incident?

What Went Right?

The response to this incident included:

- Immediate help was given to the injured employee, who sought medical attention.
- Notification was given to the appropriate offices and personal.
- Subsequent documentation and processing.

At WAPA we are dedicated to enabling our employees to practice safe working habits. As part of this effort, we commit ourselves to learning and improving continuously.

Near-miss reports

WAPA F 420.2
(4/15)

U.S DEPARTMENT OF ENERGY
WESTERN AREA POWER ADMINISTRATION
"NEAR-MISS" REPORT

To include information that would identify you or your location is optional (it may help if we need more details or to return feedback to you.)

Date of Incident: 10/4/2018

Location of Incident: Grape Vine Pass (GVP) communications site

Equipment Involved (If any):
2016 Ford Expedition

Describe, in detail, exactly what happened (continue on back of sheet or add pages if necessary):
I was going to the site to perform microwave maintenance. There is a rugged dirt/gravel road going to the site, with the upper half having some steep sections. It had rained a few days before but the current road condition was dry and no rain was forecasted. I placed the vehicle in 4WD (my usual procedure) and proceeded up to the site. About 2 hours on site, it started to rain hard for about 20 minutes. I completed my work 2 hours later and prepared to depart the site. Still in 4WD, I started down the hill slowly and immediately started to slide. I was able to stop the slide. I tried to back up but was unable due to the slope and slick road. I decided to proceed with caution down the hill, inching my way down. The rear-end of the vehicle started coming around several times and I had to "cross it up" to keep it on the road. What normally takes 10 minutes took me 35 minutes.

Recommended Actions and/or Lessons Learned:
Don't assume that making it up a grade is hard part. Coming down is just as important. I recommend the road be reworked with more rock base to prevent mud from clogging the tires and providing better traction.

WAPA F 420.2
(4/15)

U.S DEPARTMENT OF ENERGY
WESTERN AREA POWER ADMINISTRATION
"NEAR-MISS" REPORT

To include information that would identify you or your location is optional (it may help if we need more details or to return feedback to you.)

Date of Incident: 2/22/18

Location of Incident: I-10 west bound and 51st Ave.

Equipment Involved (If any):
Ford F-350

Describe, in detail, exactly what happened (continue on back of sheet or add pages if necessary):
A lineman turned his F-350 in for an oil change and tire rotation/balance to the DSW fleet department. On February 22 he was informed by fleet that the work on his vehicle was completed so he and a fleet rep. went to the dealership to get the vehicle. The lineman then drove the vehicle back to the shop and fueled up with no issues . As he left the shop he heard a noise and felt some vibration. The lineman then pulled over and called fleet to report that he was taking the vehicle back to the dealership. After merging onto I-10 going west the vibration worsened and in the process of coming to a stop the tire fell off the vehicle leaving him stranded in heavy traffic. The dealership admitted failing to tighten the lug nuts and excepted full responsibility.

Recommended Actions and/or Lessons Learned:
When vehicles are taken in for service by fleet management they should verify that the services are properly done before returning the vehicle to the owner. Although the work is done by professionals the operator should always make sure the vehicle is safe to drive.

Fall protection

Drone work

Human external cargo

Disaster response

Our loss

Contact/follow me

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